College Insurance Program
TRAIL Medicare Advantage Enrollment Form

For Plan Year 2017 (January 1 through December 31, 2017)

Total Retiree Advantage Illinois
Your Trail to Better Health

FOR POSITION ONLY

Preprinted Name
Preprinted Address
Address Line 2
City, State and Zip Code
Intelligent Mail Barcode

Please return form to:

State Universities Retirement System
1901 Fox Drive
P.O. Box 2710
Champaign, Illinois
61825-2710
Phone number: (800) 275-7877
Fax number: (217) 378-9800

IF THE ABOVE PREPRINTED MAILING ADDRESS IS INCORRECT, ENTER THE CORRECT ADDRESS ON THESE LINES.

Complete **SECTION 1** if you are **ENROLLING IN A MEDICARE ADVANTAGE PLAN FOR THE FIRST TIME. If you're a current TRAIL member and have no changes, disregard this form and your TRAIL MAPD coverage will continue.**

SECTION 1: MEMBER INFORMATION

Please fill in the information below as it is on your Medicare card.

MEDICARE HEALTH INSURANCE

Last Name

First Name MI

Medicare Claim Number

Is Entitled to

HOSPITAL (PART A) Effective Date

MEDICAL (PART B) Effective Date

Date of Birth Gender ☐ M ☐ F

Social Security Number

Email Address

Home Phone Cell Phone

County of Residence

Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**

SECTION 2: RESIDENTIAL ADDRESS

RESIDENTIAL ADDRESS (if different from **mailing** address)
You must enter a physical location in the section below if the address preprinted above is a P.O. Box
(Do not enter a P.O. Box or a General Delivery Address)

Do you reside in a nursing home or assisted living facility? ☐ **Yes** ☐ **No**
If YES, the nursing home/assisted living facility address must be entered below:

Street Address Apt. or Suite

City State Zip Code County

Complete **SECTION 3** if you are **(1) ENROLLING IN A MEDICARE ADVANTAGE PLAN FOR THE FIRST TIME, (2) WISH TO CHANGE** your current Medicare Advantage health plan election or are **(3) ELECTING TO CANCEL** your CIP coverage.

SECTION 3: COVERAGE ELECTIONS FOR 2017

OUR SYSTEM SHOWS YOUR CURRENT HEALTH PLAN IS:

FOR POSITION ONLY
Health Plan Name

DEPENDENT COVERAGE – If you have a spouse, civil union partner, parent or disabled child currently enrolled on your CIP coverage, they will remain enrolled and will have the same coverage you have. If you change your health plan or add a dependent to your coverage, your dependent must sign page 3. To add or drop a dependent, complete page 4.

HEALTH PLAN ELECTION (select one)

Preferred Provider Organization (PPO) – available nationwide

☐ **UnitedHealthcare PPO** (AE)

OR

Health Maintenance Organization (HMO) (See map on page 16 of the Decision Guide)

Check a box below to indicate your HMO plan election:

☐ **Coventry Advantra HMO** (AB)

Member's PCP name | Spouse/Partner's PCP | Other Dependent PCP

Physician's NPI# | Physician's NPI# | Physician's NPI#

☐ **Health Alliance MAPD HMO** (AF)

Member's PCP name | Spouse/Partner's PCP | Other Dependent PCP

Physician's NPI# | Physician's NPI# | Physician's NPI#

☐ **Humana Health Plan HMO** (AD)

Member's PCP name | Spouse/Partner's PCP | Other Dependent PCP

Physician's PCP# | Physician's PCP# | Physician's PCP#

☐ **Humana Benefit Plan HMO** (AC) (Livingston and Knox Counties Only)

Member's PCP name | Spouse/Partner's PCP | Other Dependent PCP

Physician's PCP# | Physician's PCP# | Physician's PCP#

OR, **CANCEL MY CIP COVERAGE**

☐ **I wish to cancel my CIP coverage. I understand that by cancelling I will no longer have health, prescription drug, dental and vision coverage through CIP effective January 1, 2017.** I also understand that under current CIP eligibility rules, that if I cancel my coverage I will be ineligible to re-enroll in the program in the future unless I lose other group insurance coverage for reasons other than voluntary termination or nonpayment of premium.

FOR POSITION ONLY
Benefits Code FPO

SECTION 4: SIGNATURE OF PLAN PARTICIPANTS

By signing below, I am agreeing that I have read and understand the important information on page iii of the Instruction Sheet.

SIGNATURE OF MEMBER or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.) _____ Date _____

SIGNATURE OF SPOUSE/CIVIL UNION PARTNER or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.) _____ Date _____

SIGNATURE OF OTHER DEPENDENT or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.) _____ Date _____

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, the signature certifies that: (1) this person is authorized under State law to complete this enrollment and (2) documentation of this authority is available upon request by the Plan or Medicare.

AUTHORIZED LEGAL REPRESENTATIVE

If you are the authorized legal representative, you **must** sign the 'Signature of Member' above and provide the following information:

Last Name _____ First Name _____

Street Address _____ Apt. or Suite _____

City _____ State _____ Zip Code _____

Phone Number _____ Relationship to Applicant _____

☐ As the legal representative of the member, I would like the College Insurance Program (CIP) information mailed to my address.

If you are the legal representative signing for this member you must provide a copy of the legal document giving this authority, such as a Power of Attorney or a court order indicating that you are the member's legal guardian, along with this application. If the documentation is not submitted by the application due date, the application will be denied. **Members whose application is denied due to lack of documentation from the legal representative will not have health, prescription drug, dental and vision coverage through the College Insurance Program and will not be allowed to re-enroll in the program at any time in the future unless they lose their other coverage for reasons other than voluntary termination or nonpayment of premium.**

Complete **Section 5** if you wish to **add or drop a Medicare dependent** (spouse, civil union partner, parent or child). If you wish to add a Non-Medicare dependent, see page iv of the Instruction Sheet.

SECTION 5: DEPENDENT COVERAGE

1. Drop a Dependent – if you wish to **drop** a currently enrolled dependent from your coverage, check the box for the relationship of the dependent you are dropping. If the dependent is a child, indicate the first name of the child. Coverage will be terminated effective January 1, 2017.

☐ Spouse or Civil Union Partner ☐ Parent

☐ Child, indicate name: _____

2. Add a Dependent – if you wish to **add** a dependent to your Medicare Advantage plan coverage, complete the information below. **You may only use this form to add a dependent that has Medicare Parts A and B.** Please fill in the information below as it appears on your dependent's Medicare card. Documentation, as indicated on page iv of the Instruction Sheet, is required to add a dependent. Each dependent must sign page 3.

Dependent 1: Relationship of Dependent to Member ☐ **Spouse** ☐ **Child** ☐ **Civil Union Partner** ☐ **Parent**

MEDICARE HEALTH INSURANCE

_____
Last Name

_____ _____
First Name MI

_____
Medicare Claim Number

Is Entitled to
HOSPITAL (PART A) _____ **Effective Date**

MEDICAL (PART B) _____ **Effective Date**

_____ Gender ☐ M ☐ F
Date of Birth

_____
Dependent's Social Security Number

Does this dependent have End–Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**

Dependent 2: Relationship of Dependent to Member ☐ **Spouse** ☐ **Child** ☐ **Civil Union Partner** ☐ **Parent**

MEDICARE HEALTH INSURANCE

_____
Last Name

_____ _____
First Name MI

_____
Medicare Claim Number

Is Entitled to
HOSPITAL (PART A) _____ **Effective Date**

MEDICAL (PART B) _____ **Effective Date**

_____ Gender ☐ M ☐ F
Date of Birth

_____
Dependent's Social Security Number

Does this dependent have End–Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**

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